Transitioning Residents from Nursing Facilities to Community Living: Who Wants to Leave?

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ABSTRACT

OBJECTIVES: To examine nursing facility residents' or their legal proxies' perspectives on transitioning out of nursing facilities by assessing residents' perception of their ability to live more independently, their preference to leave the facility, and the feasibility to transition with community support.

DESIGN: Analysis of survey findings from the California Nursing Facility Transition Screen (CNFTS).

SETTING: Eight nursing facilities in southern California.

PARTICIPANTS: All custodial, long-stay residents receiving Medi-Cal (California's Medicaid program, n=218). Of these, 121 (56%) self-consenting residents or legal proxies were interviewed. No presumptions were made as to which residents were appropriate candidates for transition based on health or functional capacity.

MEASUREMENTS: CNFTS contains 27 open- and closed-ended questions on preference, ability, and feasibility of transitioning.

RESULTS: Twenty-three percent believed that the resident had the ability to transition, 46% indicated a preference to transition, and after discussing potential living arrangements and services, 33% thought that transitioning would be feasible. Among those who consented to allow access to their Minimum Dataset 2.0 (MDS) information (n=41; 34% of the sample), agreement in the assessment of preference was found in 39% of cases.

CONCLUSION: Transition decisions are complex and include preference as well as perceptions of the resident's ability to live in a more independent setting and the feasibility of transitioning. Compared with the MDS, the screen identified a higher proportion of residents who want to

transition, suggesting that a systematic approach to assessing the complex decision to transition is needed.

Key words: custodial care, nursing facility residents, living arrangements, relocation

INTRODUCTION

For over two decades, long-term care policy efforts focused on home and community-based alternatives to institutionalization. In 1999, these efforts became a federal imperative with the Olmstead Decision, in which the Supreme Court determined that unnecessary institutionalization violates the Americans with Disabilities Act of 1990 (ADA) (1). To assist states in promoting community-based alternatives, Centers for Medicare and Medicaid Services' (CMS) provided Nursing Home Transition Grants starting in 1998 which tended to target persons under age 65. In 2003, under the New Freedom Initiative, CMS offered Money Follows the Person Grants as part of rebalancing initiatives to transition persons out of the nursing facility and promote flexible financing systems that follow the individual to the most appropriate setting. The Deficit Reduction Act of 2005 awarded further demonstration grants for rebalancing and increased federal Medicaid matching funds for home and community-based services for transitioned individuals (2). A first step in rebalancing is to identify institutional residents who wish to transition, but research is lacking.

While it is clear that most community-dwelling older adults want to remain in their own homes (3), little is known about the extent to which long-stay nursing facility residents of any age prefer to transition to community settings. This study used a comprehensive instrument to explore three interrelated dimensions inherent in long-stay residents' decision to transition out of the facility, the resident's: 1) perceived ability to leave, 2) preference, and 3)feasibility of transitioning based on community-based supports.

Understanding the Preferences of Nursing Facility Residents

Both admission and annual assessments of the Minimum Dataset 2.0 (MDS), completed for all residents in state and federally certified nursing facilities, include one question about

preference to return to the community. However, this single question is not uniformly asked of every resident and instructs assessors to use indirect questions with long-stay residents to avoid creating unrealistic expectations: “It’s been about 1 year that we’ve known each other. How are things going for you here at (facility)(4)?”

The indirect approach is defensible if residents are clear and spontaneous in expressing preferences. However, long-stay residents may not consider transitioning an option because of a loss of prior housing or an unquestioning acceptance of facility life. A study of residents in three nursing facilities with light care needs found that 70% (n=20) did not want to remain in the facility, all but one believed that no other option existed (5). Furthermore, availability of home and community-based services to support transitioned long-stay residents varies widely by state (6). Even if community options exist, residents, family, and legal proxies may be unable to identify and access community-based resources (e.g., accessible housing and transportation).We are not aware of other instruments that systematically assess long-stay residents receiving custodial care or gather comprehensive information on various dimensions of the transition decision using standardized protocols. Instruments such as the MDS allow interviewers wide flexibility in how or even if preference questions are asked. Apart from the MDS, it is unclear whether other studies have included residents with dementia in transition interviews and if so, how many residents could not respond or had proxies for health care decisions. A clear description of when proxies are used is an important issue in research with long-stay residents.

The study targeted long-stay custodial care residents funded by Medicaid, and excluded those admitted for short-stay Medicare-funded rehabilitation, which is a crucial distinction in research (7,8). Studies indicate that residents who remain in the facility are more likely to have a cognitive disorder and to be covered by Medicaid (9,10). In targeting residents for transition, it is

important to differentiate custodial care residents who are unnecessarily residing in institutions from those who are short-stay and will eventually return to the community without an intervention. For example, in 1998, New Jersey launched the Community Choice Counseling Program and an evaluation indicated that 1975 clients were transitioned, 86% of whom were satisfied with their transitional living situation (11). Yet, it is unclear how many long-stay custodial residents were targeted.

Using a comprehensive screen, the following questions were addressed of residents or where necessary, their proxies: 1) What proportion of long-stay residents believe that they are able to transition to a community-based setting? 2) What proportion prefer to leave the facility? 3) After discussing available community supports, what proportion believe that transition is feasible? 4) Are transition decisions stable over time? 5) How does using a comprehensive screen administered to all consenting custodial Medicaid-funded residents compare to transition preferences identified by the MDS?

METHODS

The Development of the California Nursing Facility Transition Screen (CNFTS)

The California Nursing Facility Transition Screen (CNFTS) was developed from reviews of other instruments (e.g., MDS), input by key stakeholder groups representing persons with disabilities and older adults, and pilot tests in two southern California nursing facilities. Criteria for the screen were that it assessed preference from all Medi-Cal (California's Medicaid) residents within a facility, was not taxing to complete, and did not create unrealistic expectations about transitioning opportunities. The University of California Los Angeles Institutional Review Board approved all facets of the project. The screen includes 27 open- and closed-ended questions on reasons for entering the nursing facility, preference to transition, and ability to return to the community. To ensure that respondents are aware of housing and community options before assessing the feasibility of transitioning, the instrument explores potential living arrangements and services.

Participants and Setting

The study targeted all English-speaking residents receiving custodial (long-term) care covered by Medi-Cal in eight nursing facilities in southern California (n=218). Residents paying privately and those receiving Medicare-funded rehabilitation were excluded. Non-English speaking residents (n=4) were excluded from this pilot phase. Seven skilled nursing facilities were affiliated with for-profit nursing facility chains, and one was an independent for-profit facility. Exclusion criteria included locked psychiatric facilities, rehabilitation or sub-acute facilities, and facilities for the developmentally disabled.

Purposive sampling was used based on inclusion and exclusion criteria. A consultant to the California Association of Health Facilities described the project at a southern California

meeting. Eight homes were recruited from nine volunteer facilities that were located in the catchment areas of community agencies assisting in transition. Data retrieved from a public California website confirmed that the facilities were not atypical of California facilities based on resident characteristics including age, dementia prevalence, and length of stay.

Procedure

With privacy safeguards in place, each nursing facility identified all residents whose stay was funded by Medi-Cal and was expected to be long-term. Interviewers were graduate students who received four hours of training and conducted practice interviews with oversight from a co-investigator to maximize inter-rater reliability. The resident's face sheet identified self-consenters and those who required a legally designated proxy for health care decisions. Nursing facility staff confirmed this information and stated that this is the same person listed on the MDS as responsible for medical decisions. Because the study did not exclude participants based on cognitive status, the majority had a proxy reflecting the high number of residents with impaired cognitive functioning who reside in nursing facilities. Although it is possible that some residents (e.g., with Durable Powers of Attorneys) were cognitively alert and able to express preferences, without HIPAA consent, cognitive information could not be accessed. Using a script, researchers contacted self-consenters in person (n=44). Proxies were contacted by telephone (n=178) because it was not known when or if the proxy would visit the facility. The majority of proxies were family members (76%) and the remaining were Durable Powers of Attorneys, conservator/guardian, trustees, or friends. Three attempts were made to contact the proxy by telephone during different times of the day and using all available contact numbers; a script was used to leave messages, introduce the study, and obtain consent. It made clear that all responses would be kept confidential and that participation would not affect care received at the facility.

All who agreed to participate (n = 121) were asked to sign a Health Insurance Portability and Accountability Act of 1996 (HIPAA) consent; 34% (26 residents, 15 proxies) did so. Participants who were interested in transitioning were more likely to consent and those with a preference to stay were significantly more likely to decline; some were offended by the request (χ^2= 45.82, *P*<.001). Preference information from the most recent full MDS (item Q1.a) were compared with the CNFTS. Analyses also compared responses to Activities of Daily Living (ADL) questions (transferring, eating, bed mobility, toileting, personal hygiene, bathing, walking, and dressing) on the CNFTS and MDS. After collapsing the MDS scale into a dichotomy (no difficulty/difficulty) to facilitate comparison with the CNFTS, two out of nine items were significantly different: bathing (χ^2 = 4.31, p = .038) and transferring (χ^2 = 7.07, p = .008). In both cases, participants indicated no difficulty whereas the MDS reported difficulty. Finally, residents who believed transitioning was feasible were asked to sign a release consent to share information with community agencies.

To assess inter-rater reliability of the CNFTS, 12 interviews were conducted, in which two interviewers coded participants' responses. Agreement was 100% on participants' preference to relocate with an 84% agreement and a mean kappa of 0.77 across all numeric items. In addition, all proxy respondents were asked for consent to conduct a second interview of the resident to examine proxy reliability issues. Only 9% (8 out of 88) permitted a second interview, and three of these residents did not consent. Of the remaining five cases, both proxies and residents reported the same preference toward relocation.

RESULTS

Securing Participation in the Study

As Figure 1 shows, 218 Medi-Cal residents were eligible for the study including 44 (20%) self-consenting residents and 174 (80%) proxies. Researchers were able to contact 178 respondents including all residents and 77% of proxies. Sixty-eight percent of those contacted (n=121) consented to the screen resulting in a sample of 33 self-consenting residents (75% of all self-consenters) and 88 proxies (66% of proxies contacted; 51% of all proxies). Forty-one out of 57 participants who did not consent provided researchers with an explanation including: health problems that required 24-hour care (n = 27), not interested (n=10), satisfied with the facility (n=3), and unwilling to provide personal information (n=1).

(PLACE FIGURE 1 ABOUT HERE)

Ability and Preference to Leave the Nursing Facility

Participants were first asked about *ability* to transition: "Do you think you (your relative) would be able to leave the nursing facility and live somewhere else now?" Most (69%; n=84) responded that the resident was not able to leave; 23% (n=28) indicated that the resident was able, and 7% (n=9) were unsure. Although more than twice as many proxy as resident interviews were conducted, only 25% (n=7) of those indicating that the resident was able to leave were proxies whereas 75% (n=21) were residents (χ^2= 8.72, *P*=.013). When asked why the resident was unable to leave, 81% (n=68) gave a reason including need for facility level of care (n=34; 50%), inability to perform basic activities such as walking or eating (n=23; 34%), and safety concerns (e.g., falling, wandering) (n=4; 6%).

Interviewers then tapped the second component of the decision to leave— *preference*: "Would you (your relative) want to live somewhere other than the nursing facility?" Almost half

(n=56; 46%) indicated that the resident wanted to leave the facility; 35% (n=42) did not want to leave; and 19% (n=23) did not know. A greater percentage of proxies (n=36; 86%) than residents (n=6; 14%) responded that the resident did not want to leave the facility (χ^2= 16.09, *P*<.001). To determine why participants did not want to transition, they were asked: "What are some reasons you (your relative) want(s) to continue living in the nursing facility?" Thirty-four of the 42 participants who did not want to leave provided responses: 1) need for a high level of care (n=19; 56%); 2) like nursing facility and/or staff (n=10; 29%); and 3) nursing facility is the most appropriate placement (n=5; 15%). About one in five (n=24; 20%) indicated that residents were able to transition and preferred to leave.

The next section of the CNFTS provides information about community-based living arrangements and supportive services. Participants were asked if they thought various housing and service programs were good options for the resident. Among those who responded "no" or "don't know," the interviewer listed ADLs and Instrumental Activities of Daily Living (IADLs) and asked if the response would change if the resident could get assistance with these tasks. If the participant said "yes" or "don't know," the interviewer proceeded with the next section. If the respondent again said "no," the interview was stopped. For respondents who initially said "yes" to the question about living arrangements and types of support, the interviewer also listed ADLs and IADLs and asked if assistance in these areas was important for the resident. Fifty-two respondents (43% of those asked) said either "yes" or "don't know" to the question of the need for or benefit of support; for these respondents, the interviewer proceeded with the next section.

Living Arrangements and Assistance

Those who continued the screen were asked to identify one or more potential living arrangements if the resident transitioned from the facility. Responses were: no place to go (n=17;

33%), live alone in an apartment or home (n=14; 27%); live with other family members (n=12; 23%) or with a partner/spouse (n= 3; 6%); assisted living facility (n=4, 8%); and group home (n=7, 13%).

To further examine the need for support and the capacity for transitioning, interviewers asked respondents about need for assistance with ADLs (transferring, eating, bed mobility, toileting, personal hygiene, bathing, walking, dressing) and IADLs (telephone, cooking, medications, housework, shopping, transportation, managing money). Residents had a mean of three ADLs (3.0±1.7), with most needing help with bathing or showering (n=44; 85%) and dressing (n=34; 65%). Residents or proxies reported a mean of 5.6 (±1.6) IADL difficulties. Most problematic were housework (n=49; 94%), shopping (n=47; 90%), and transportation (n=47; 90%).

Feasibility of Transitioning

The interview concluded by asking: "If you had help available for any of these services, would you (your relative) be able to leave the nursing facility?" Although this question is identical to the earlier question about ability to transition, it was posed after a discussion of preferred living arrangements and services needed. Of the 52 respondents who completed the entire screen, 40 (77%) believed that transitioning was feasible, seven (13%) stated it was not feasible, and five (10%) were unsure. Of the 40 respondents who believed that leaving the nursing facility was feasible, the majority were self-consenting residents (n=26; 65%) rather than proxies (n=14; 35%,) (χ^2= 8.72, *P*=.013). Therefore, of the 121 who were initially interviewed, 28 (23%) thought that the resident was able to transition, 56 (46%) indicated a preference to leave, and after learning about service and community living options 40 (33%) believed that transitioning was feasible.

Feasibility of Transitioning: Stability Over Time

To assess stability, all 40 participants who indicated that transition was feasible were re-interviewed approximately three weeks later. Most (n=34; 85%) consented to a second interview—23 residents and 11 proxies. Overall, 27 participants (79%) responded with a stable affirmative response toward transitioning; 17 were residents (74% of the resident sample) and 10 proxies (91% of the proxy sample). Among these 27 participants, 81% (16 residents, 6 proxies) completed release forms to enable researchers to refer their cases to a community-based agency.

Comparison With MDS Preference Question

Among the 121 residents who consented to the interview, permission was obtained to secure MDS data on 34% (n=41). Preference data from CNFTS were compared with MDS question Q1a: "Resident expresses or indicates a preference to return to the community." Agreement with the CNFTS and MDS Q1a was found in 39% of responses (n=16). For 46% of responses (n=19), the screen indicated that the resident preferred to transition and the MDS indicated that the resident did not want to leave ($\chi^2 = 4.67$, $p = .097$). In one case, the MDS indicated that the resident had a preference to leave whereas the CNFTS found the opposite. Twelve percent (n=5) were unsure according to the screen; the MDS was recorded as "no."

Comparing Resident Characteristics

For those who provided HIPAA consent, Table 1 compares characteristics of those who believed transitioning was feasible with those who did not want to transition. Respondents in the latter category responded "no" to at least one of the questions on ability, preference, or feasibility. One participant who provided consent was omitted from the table because he/she was unsure whether transitioning was feasible. Although the power to identify differences was reduced because only one-third of the original sample signed a HIPAA consent (26 residents, 15

proxies; 34%), it is clear that participants who thought transitioning was feasible were less cognitively impaired and younger.

(PLACE TABLE 1 ABOUT HERE)

DISCUSSION

Given increasing support for consumer choice and state-level policy momentum driven by the Olmstead Decision, rebalancing efforts, and Money Follows the Person grants, the goal of the study was to investigate long-stay residents' attitudes toward leaving 24-hour facility care. Attempts to interview all Medi-Cal residents or their proxies using no health or functioning exclusion criteria resulted in a sample of 121 out of 218 eligible to participate (56%). When asked about residents' perceived ability to move, the percentage of affirmative responses was less than one-quarter (n=28; 23%). A focus on preference rather than ability, however, resulted in doubling positive responses (n=56; 46%). Finally, after consideration of needs and options, 33% (n=40) considered it feasible to transition from the facility. As these results indicate, transition is a complicated decision in which the individual weighs both the capacity and the desire to relocate as well as the community support available to meet anticipated care needs. The answer to who would like to transition depends on how the question is asked.

It can be argued that those residents and proxies who believed that transition was feasible were most serious about transitioning and most likely to work closely with community agencies on the complicated tasks of securing housing and arranging for services. Respondents may want to move and believe in their ability to leave, but the discussion of available living arrangements and service needs helped to illuminate potential assistance as well as difficulties prior to stating the feasibility of transitioning.

In terms of stability of the transition decision, most participants who consented to a second interview continued to believe that transitioning was feasible (n=27; 79%). Instability in the remaining 21% reflects the gravity of transition decisions. This subset could be targeted for further educational or supportive efforts to better understand their concerns. As we could not find

another study that reported the stability of residents' preferences toward transition, we were unable to determine if the design of the CNFTS produced a higher rate of instability than alternative methods of questioning. In practice, more than one interview may be necessary to enable residents and families to reflect on this important decision, although care must be taken not to harass those who are firm in their choice. Furthermore, 81% of participants (22 of 27) who completed the release form took a proactive step that demonstrated their commitment to transition. These residents, who were referred to community-based agencies to begin the transition process, can be seen as a test of the effectiveness of the screen.

A corollary goal was to compare findings from the CNFTS to the MDS. The MDS assesses preference with a single item based largely on the assessor's judgment and cautions assessors against creating unrealistic expectations. By systematically interviewing all long-stay Medi-Cal funded custodial residents and proxies regardless of residents' health or cognitive status, the screen identified a large proportion who wanted to transition even though the MDS indicated a lack of preference to leave (n=19; 46%). Although about one-third of participants allowed access to their medical records, this finding suggests that a direct questioning approach should be employed and does not create unrealistic expectations because participants acknowledged that some residents needed a high level of care or that the nursing facility was most appropriate. At the same time, we do not argue that the CNFTS is better than others in use because we cannot find published data about whether other protocols worked with custodial residents.

This is a pilot study that explores a previously unaddressed issue in the geriatric literature—long-stay residents' perspectives on transitioning out of the facility. Several limitations should be considered. First, the nursing homes, although similar in most

characteristics to other southern California facilities, were volunteers and one cannot rule out a selection bias that may make their resident populations unique. This type of selection bias is present in all research that cannot mandate a nursing home's participation. Second, question wording in the screen was not identical to the MDS because the latter contains an inadequate, vague question about preference (i.e., "How are things going for you?" (4)). Further complicating the comparison, relatively few people who did not want to transition permitted access to their records. Also, the MDS preference question is only asked upon admission and annually thereafter, so responses could be up to 12 months old. These factors limit the ability to determine if the discrepancy between the MDS and the CNFTS is due to method of questioning or timing issues.

Thirdly, the study did not conduct stability interviews with residents or proxies who said "no" to the move, and some of these participants may later change their mind. This is a significant limitation, but many proxies were definite that the resident could not move and did not want further contact. Furthermore, the majority of proxies did not permit a second interview with residents to examine reliability. In addition, in the script for the CNFTS, a range of community-based options were listed. However, it may have been more effective to provide specific examples of persons with similar needs who are successfully residing in the community. Fourth, only English-speaking residents were interviewed.

Fifth, it is important to acknowledge our substantial sample loss because proxies could not be located or refused to participate. It is unclear how these proxies would have responded and in fact, some could have been in favor of relocation if the protocol included an education component. Moreover, proxies may have changed their mind if educated about community supports or by observing other residents successfully transition. However, it also is likely that

these efforts would be unsuccessful in a group that was unwilling to complete a 10-minute interview. The percentage of people who want to transition was determined by dividing the number that expressed this preference by the number that was interviewed. If the denominator included those who refused the interview, then the percentage would be reduced.

Finally, interviewing all long-stay, custodial residents had two implications, which are not study limitations but rather issues that must be confronted when conducting studies with cognitively-impaired residents. First, respondents who were designated proxies had to be approached first, which is necessary unless a new ethical and legal argument can be developed and accepted by Internal Review Boards. Secondly, it is possible that some proxies did not consent to the interview after learning its purpose because they strongly believed that the resident was too impaired and that the nursing facility was the best living arrangement. In addition, Medi-Cal completely covered the cost of the nursing facility stay. In the community, it is unlikely that all expenses would be covered.

Although one cannot assume that all self-consenting residents want to relocate, residents who were able to self-consent were more likely to express a stable preference to transition. If interviews with all long-stay residents are not feasible in practice, the findings suggest that self-consenting residents are excellent targets for transition and MDS item ‘A9,’ which records the legal proxy decision-maker, could be utilized. Fewer interviews would need to be conducted and a higher number of transition candidates may be identified. Future efforts could also examine the impact of proxy relationship (e.g., family, legal guardian) on transition preferences.

This study represents an important first step in an area with no previous systematic research. We approached and enabled all long-stay, Medi-Cal funded custodial nursing facility residents to express their preferences and beliefs without presumptions as to which residents

were good or bad transition candidates. The interview identified a significant proportion of people expressing a preference to relocate, an important population according to Olmstead principles. In supporting the philosophy of consumer direction, the CNFTS presents both the opportunity and means for long-stay nursing facility residents to create a different future for themselves and receive the needed resources to meet this goal.

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CONFLICT OF INTEREST

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Christy M. Nishita was responsible for study concept and design, data entry, analysis and interpretation of data, and the preparation of the manuscript.
Kathleen H. Wilber was responsible for study concept and design, interpretation of data and the preparation of the manuscript.
Saki Matsumoto was involved in data collection and analysis.
John F. Schnelle was responsible for study concept and design, interpretation of data and the preparation of the manuscript.

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Table 1. Comparison of Participants Who Responded Yes to Transitioning Versus Those Who Stated No to Transitioning Among Participants Providing HIPAA Consent (Total n=40)*

	Yes to Transitioning (22 Residents, 8 Proxies)		No to Transitioning (3 Residents, 7 Proxies)	
	N	%	N	%
Resident's Gender				
Male	14	46.7%	2	20.0%
Female	16	53.3%	8	80.0%
Resident's Ethnicity				
White, Not Hispanic	14	46.7%	6	60.0%
Hispanic	1	3.3%	1	10.0%
Black	10	33.3%	3	30.0%
Asian/Pacific Islander	4	13.3%	0	0.0%
American Indian/Alaskan Native	1	3.3%	0	0.0%
Resident's Marital Status †				
Never Married	13	43.3%	1	10.0%
Married	5	16.7%	1	10.0%
Widowed	8	26.7%	2	20.0%
Divorced	4	13.3%	6	60.0%

	Yes to Transitioning (22 Residents, 8 Proxies)		No to Transitioning (3 Residents, 7 Proxies)	
Resident's Cognitive Skills for Decision Making ‡				
Independent- Decisions Consistent/Reasonable	17	56.7%	2	20.0%
Modified Independence- Some Difficulty in New Situations Only	5	16.7%	1	10.0%
Moderately Impaired- Decisions Poor, Cues or Supervision Required	8	26.7%	4	40.0%
Severely Impaired- Never/Rarely Made Decisions	0	0.0%	3	30.0%
Resident's Memory				
Short-term Memory Problem	14	46.7%	7	70.0%
No Short-term Memory Problem	16	53.3%	3	30.0%
Long-term Memory Problem‡	8	26.7%	7	70.0%
No Long-term Memory Problem‡	22	73.3%	3	30.0%
Resident's Age‡	70.6±16.1		82.2±6.3	

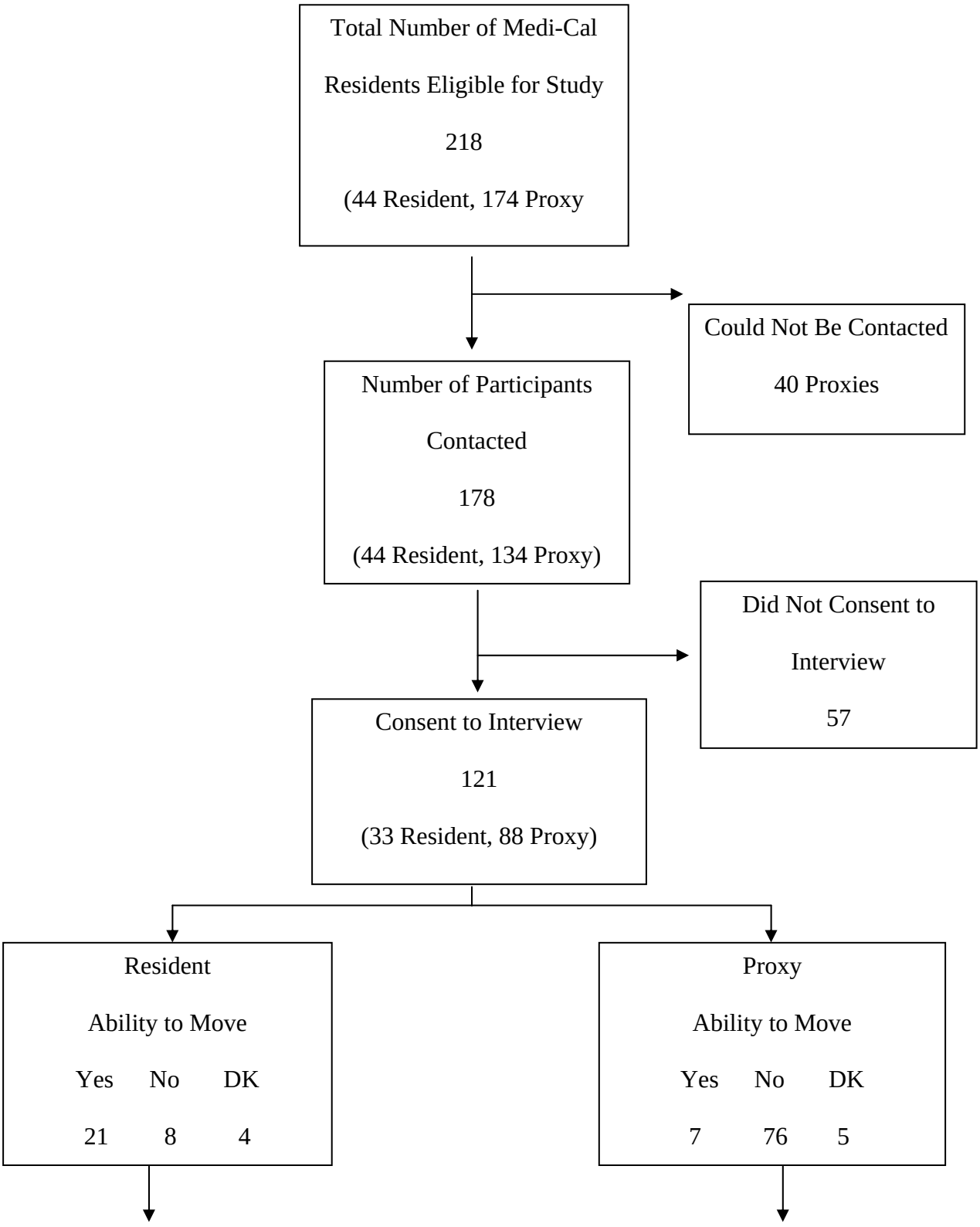
	Yes to Transitioning (22 Residents, 8 Proxies)	No to Transitioning (3 Residents, 7 Proxies)
Resident's Number of Diseases/Conditions	4.7±2.7	6.0±3.3
Number of ADL Tasks in Which the Resident Needs Extensive to Total Assistance	4.6±3.3	5.2±3.1
Number of Days in the Nursing Facility	600.8±623.9	824.8±539.3

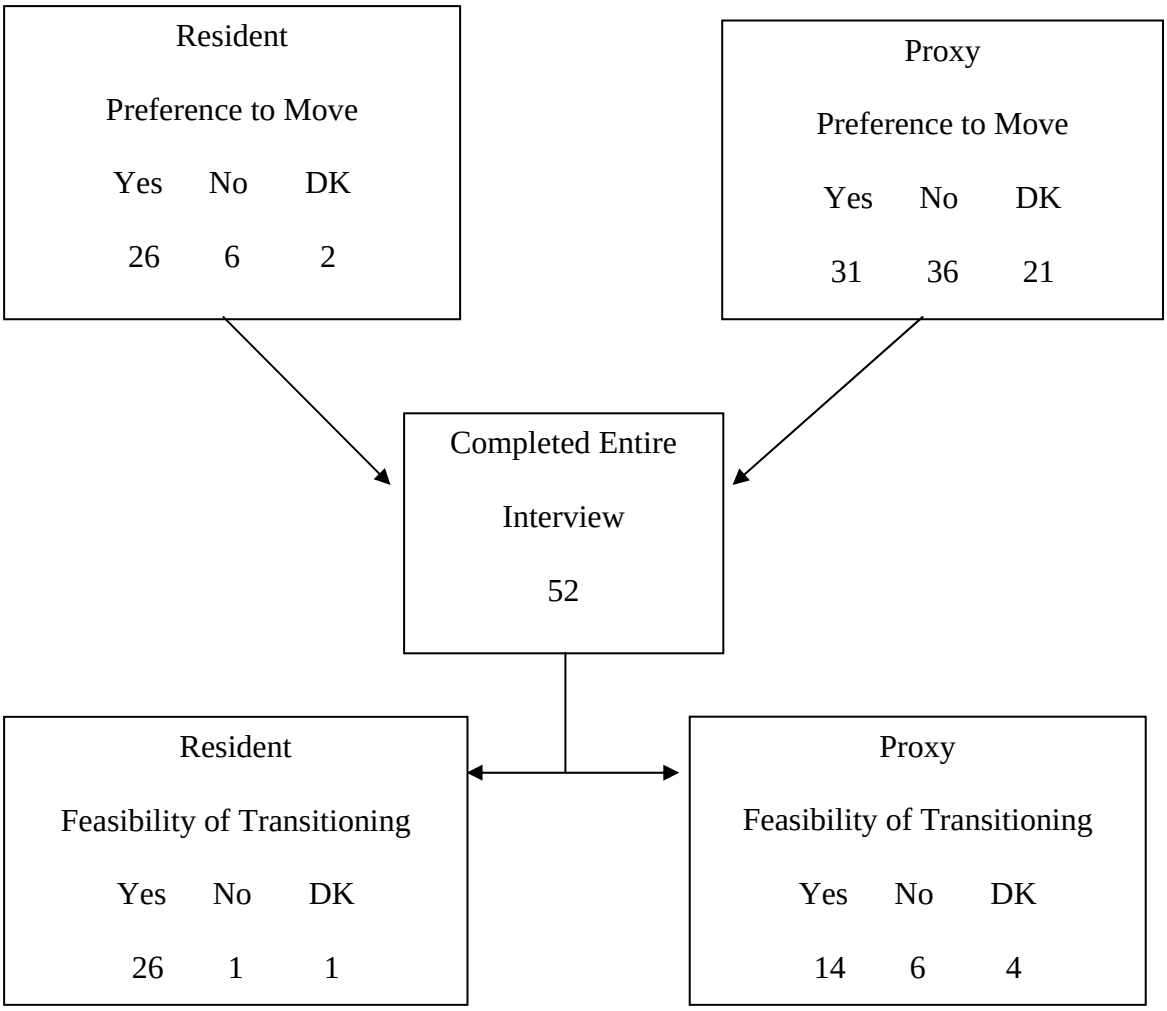
*One participant who signed the HIPAA consent form was excluded from this table because the participant was unsure whether transitioning was feasible. All participants in the "Yes to Transitioning" category responded yes to the feasibility question. Participants in the "No to Transitioning" category responded no to at least one of the questions on ability, preference, or feasibility.

† $p<.05$

‡ $p<.10$

Figure 1. Flow of Participants Through the Study and Responses to the Transition Screen





Note: DK= Don’t Know